INTERFACILITY TRANSPORT TASK FORCE

MEETING
AUGUST 30, 2005 LITTLETON, NH

Members present:

Dave Dubey, Berlin EMS/ EMS Coord. Board; Clay Odell, NHBEMS; Kim Thayer, Littleton Reg. Hosp.; Jeanne Erickson, Speare Memorial Hospital; Alisa Butler, DHHS-Rural Health; Chandra Englebert, Weeks Medical Center

A new member, Tinker Kiesman, owner of North Conway Ambulance Service was introduced

Members excused: Kurt Lucas, Littleton Regional Hospital

Members absent:

Robin Gagnon, Woodsville Ambulance; Scott Howe, Weeks Medical Center; Deanna Howard, DHMC, Nick Mercuri, LRGH/Trauma Medical Review Comm.; Adam Smith, Ross Ambulance; Michelle Willette, Stewarts Ambulance; David Santamaria, Stewarts Ambulance, Jonathan Dubey, Berlin EMS

- Clay Odell distributed an overview of the training program for ED nurses to enable them to serve as the second crew member of an ambulance during interfacility transport. This is related to the passage of Senate Bill 88. There was quite a bit of discussion on this topic.

- The major effort of today's Task Force meeting was to review actions taken on the work plans from the previous meeting and to make revisions as necessary.

1. *Eliminate decision-making based on ability to pay. Pursue a process that is blinded to insurance information for ambulance service acceptance or refusal of a transfer request.*

At the July meeting, the group expressed the wish to investigate whether hospitals can add to the medical resource hospital agreement a section for those ambulance services affiliated with the Medical Resource Hospital (MRH) that wish to do interfacility transports from that MRH. By including the agreement in the MRH agreement the hospital could include revoking a service's MRH agreement if they defaulted on the agreement. The idea is that this would add some teeth to the hospital's ability to ensure that an ambulance service is complying with a requirement to accept or deny a transport request blinded to financial considerations.

Clay looked into the applicable RSA and Administrative Rules, and discussed the issue with other NHBEMS staff. The rules mention minimum requirements of the MRH agreement, but are silent on any added language. So there doesn't appear to be any restriction to adding language to the MRH. What remains to be seen is

whether a service would object to signing a contract that linked interfacility performance with the ambulance service's ability to do business (which would be impacted if a MRH agreement was suspended). But Clay's research indicated there wasn't any legal reason that it couldn't be done.

There was a discussion about how to proceed with getting a consensus of the applicable EMS services leaders about blinding the process of ambulance services accepting or declining to do interfacility transfers to the patient's ability to pay. The group consensus was to take a two-pronged approach. The first was to have a meeting of all the applicable EMS unit leaders to discuss this issue as well as several others. This approach has the ability to achieve a consensus of leadership following discussion of the issue. The second approach is to meet with the leadership of EMS units that are perceived as non-compliant, as well as the involved hospitals.

There was discussion clarifying that this concept would be for emergency transfers, not convenience transfers.

2. *Draft a generic decision tree to match patient needs with ambulance resources. This will address issues of clinicians complicating the acquisition of an ambulance because they request levels of care that are higher than the patient really needs.*

The task force members reviewed the draft document that Weeks Medical Center had composed. Chandra still has some work to do on it, but will soon send electronic copies to the group via email.

3. *Investigate the sharing of crew resources between services for episodes where a full crew is not available but an appropriate EMS provider from another service is ready and willing to serve as a crew member. Two areas to explore are inter-service agreements and a separate entity to "rent" EMS providers as needed.*

Dave Dubey reported a meeting that he had with his service's insurance agent. That gentleman's opinion is that the idea of each ambulance service "renting" their staff to supplement another ambulance service (as discussed at the July meeting) was problematic. It might tend to obscure who is liable for what in an adverse incident. He indicated that the best practice was for an ambulance service to have all their insurance (i.e. auto, malpractice, workers comp) through one carrier. That decreases the potential for insurance companies fighting over who is responsible. The insurance agent thought a better approach was to have individual EMS providers that were willing to belong to a supplemental staffing pool should actually be on the payroll of other agencies as a PRN or per diem employee.

The gentleman told Dave that he would be willing to attend the IFT Task Force meetings. There was some discussion of this concept, mostly in the positive. It was decided that this should be an issue to discuss with the leadership of the ambulance services at the meeting that we discussed under workplan # 1 above.

- Next meeting: The next meeting is scheduled for **September 27, 2005 at 10:30** at Littleton Regional Hospital. The task force appreciates Littleton Regional Hospital's continuing support for this committee's meetings.